published elsewhere in this issue, is a practicing physician in Roseburg, Oregon, and a state legislator. At age 41, he is president of the Oregon State Senate and an expert dealing with a variety of issues including public education, land use planning, water policy, and health care. His discussion of the problem of uncompensated care—its etiology, its symptomatology, its prognosis, and its possible cure—reveals the depth of his concern and expertise.

The problem of uncompensated care—giving services to those with no means to pay—is not new in America. It has been present since colonial days, and yet, the poor have always received a modicum of health care. Some came from charity but most, because of the influence of the Elizabethan poor laws, came from local political subdivisions: towns, cities, or counties. Both the facilities and the care were primitive, barely giving enough sustenance to sustain life. Gradually, the poor farms and pesthouses of the past century gave way to county hospitals, some of which became the great teaching institutions of today affiliated with medical schools. Before the 1960s the poor had easy access to these institutions. Although the accommodations on bleak and crowded wards were usually spartan, the quality of both medical and nursing care often equalled or exceeded that given in private institutions. Most of the nonprofit and religion-controlled hospitals gave a substantial number of people care at reduced rates. The fee-for-service system in existence then allowed and even encouraged providers—both physicians and hospitals—to shift costs. It permitted them to charge the wealthy more in order to pay for the care of the poor.

The principle of universal access mentioned by Dr Kitzhaber, "the idea that all Americans, regardless of their income, should have access to the health care system and to all the services it had to offer," came into full fruition during the 1960s with the enactment of Medicare and Medicaid and the growth of "private health insurance policies funded primarily through employment."

For a while this system worked quite well. America seemed to have achieved "an ideal health system." Almost everyone had access to mainline quality care: the elderly were covered by Medicare, the workers and their families by employer-funded insurance, and the poor by Medicaid. This egalitarianism of care prompted third-party payers to pay a consistent and uniform fee to each provider. This seemed fair, but over the years it effectively stopped cost shifting.

Meanwhile, the overall cost of health care escalated in two decades from 7% of the gross national product to the current 11%. This resulted from many factors, including a growing population, especially of older people, increased technology, inflation, rising expectations, and growing demands for more services. As the costs of care increased, the prosperity of the country declined, the national debt increased, workers' productivity decreased, and American businesses could no longer compete with foreign manufacturers, either abroad or at home. Neither the public nor the private sector could afford the high cost of medical care. Both reacted by cutting back their coverage. This widened the gap between the two, leaving more people without health insurance. Since these people have limited fiscal resources, they can either go without medical services or seek uncompensated care. Since shifting of costs is no longer allowed, providers are reluctant to care for this growing segment of the population.

To date, little has been done to resolve the problem except to lay blame on providers. Since physicians are perceived to be wealthy, many members of society feel that doctors should be mandated to take charity cases. In fact, some legislatures are considering making this a requirement for continued licensure. Because many nonprofit hospitals received federal funds in the past, they had an obligation to care for uncompensated patients. More and more nonprofit hospitals, however, are closing their doors because of financial difficulties. This compounds the problem. The absence of cost shifting makes the providers—physicians and hospitals—face the prospect of caring for more patients without adequate recompense, refusing them care, or sending them elsewhere: "dumping."

Neither of these alternatives leads to meaningful care for these unfortunate people. Dr Kitzhaber believes society must make the hard decisions needed to solve the problem of uncompensated care by creating a new system of health care based on limited resources and acceptance of the fact that the well-off can purchase more health care than the poor—the reality of implicit rationing. "The government," he states, "should pay for the poor regardless of their age" but not for the elderly. The new health care system that Dr Kitzhaber recommends would have a minimum of three tiers: government-sponsored for the poor; employer-funded for the workers; and a traditional fee-for-service tier for those who wish to buy the type of health care they desire.

As this concept develops, the medical profession has the responsibility of defining the various levels of care, especially the basic and minimal level available to the poor. This means that the emphasis must be placed on what is best for society, not what is best for the individual. Once the basic level of health care is defined, society has no recourse except to pay for it through government funding. If society in its collective wisdom feels that additional services are needed for the poor, it has the option to provide them based upon the amount of money it wants to spend.

In a system such as this, the money spent on health care for the poor will be used most effectively for the good of society. Working with these patients, physicians know the limitations of their service; they are not being put in the role of rationeer. If, according to Dr Kitzhaber, they feel their patients need more than the government allows, they can truly be advocates by appealing on their patients' behalf. This would allow physicians to continue to serve as agents of trust and to do anything appropriate to provide necessary medical care.

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Suction-Assisted Lipectomy—Caveat Emptor

THE ARTICLE BY BELLO and co-workers elsewhere in this issue adds to our knowledge and awareness that severe infections may ensue following suction-assisted lipectomy. The medical profession was warned of this possibility in 1982 by the ad hoc committee that was formed by the American Society of Plastic and Reconstructive Surgeons to study the subject. Five years later and with an experience of more than 100,000 cases, the society reported to the profession and the public at large a total of 11 deaths and 9 cases of serious life-threatening complications.[1] Several of the deaths were attributed to severe necrotizing fasciitis.

As with any operation, the prospect of serious infection with suction-assisted lipectomy is ever present. The risk clearly increases if the wounds are near the perineal region, and sterility is compromised by the manual manipulation that is required of the procedure. If contamination inadvertently occurs, the repetitive penetration of the soiled cannula into the depths of the areas treated can result in a disastrous widespread infection in a closed space. This occurred in a case where a physician chose to do liposuction following a tubal ligation. Having accidentally perforated the bowel with the suction cannula, fecal contamination was repeatedly plunged into multiple operative sites. A catastrophic life-threatening gram-negative infection of the abdomen, flanks, and thighs resulted.

Liposuction has wide public appeal and has rapidly become the most common cosmetic operation in the United States. This lure has elicited many ill-trained practitioners with limited surgical training or experience. Furthermore, in an attempt to court patients by lowering costs, many of these procedures are being carried out in substandard office environments that are staffed by ill-schooled personnel and where the usual operating room infection control practices are nonexistent.

Although some may elect to use prophylactic antibiotics, this use is not an umbrella against a sloppy technique. That devitalized fat is left behind is undoubtedly true; a convenient pabulum for bacteria is thus established. Equally important is the appreciation of large fluid shifts, hypovolemia, and anemia that occur if more than 2,000 ml of aspirant is removed and autologous replacement is not provided. The resulting circulatory embarrassment leaves the patient with a crippled defense. In addition, the peril of pulmonary embolism of fat or blood is always present.

Liposuction is not an innocuous procedure that can be held in casual regard. As with any other operation, it should be done in an appropriately controlled environment where peer review and accreditation of the facility exist. It can be carried out safely in well-equipped outpatient office facilities where scrupulous operating room sterility is the standard and proper patient selection is practiced. Without contest, all would agree that the procedure should only be done by practitioners with the proper background and experience in general surgery.

The ad hoc committee of the American Society of Plastic and Reconstructive Surgeons concluded that "in the hands of properly trained surgeons, suction-assisted lipectomy is normally a safe and effective means of surgically contouring localized fat deposits that do not respond to diet and exercise." Those who lack the essential training and discipline and, yet, insist on practicing liposuction are a constant threat and an imminent danger to the public at large. If we cannot professionally set proper criteria of safety in the interest of the public, governmental intrusion will surely occur and, perhaps, that time has come.

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REFERENCE

1. Five-year Updated Evaluation of Suction-Assisted Lipectomy. Chicago, Ill, American Society of Plastic and Reconstructive Surgeons Ad-Hoc Committee on New Procedures, Sep 20, 1987 [Copies of the report can be obtained from the American Society of Plastic and Reconstructive Surgeons, 233 N Michigan Ave, Suite 1900, Chicago, IL 60601]